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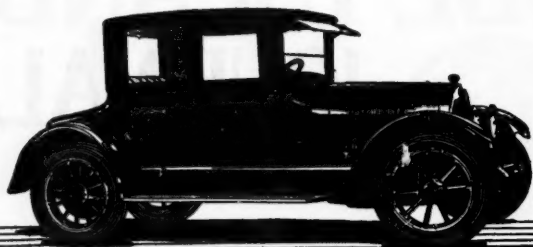
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## ORIGINAL ARTICLES

### VASCULAR HYPERTENSION.\*

By JAMES P. O'HARE, M. D.,\*

Boston, Mass.

From the purely clinical point of view, hypertension may be divided into two types—the nephritic, such as occurs with chronic interstitial nephritis, and the non-nephritic or “vascular” hypertension, as I will call it throughout my talk. I recognize the latter may be and often is the precursor of the former. Up to the present time, however, the practitioner has failed to recognize but one type and has called all cases of high pressure, especially those with albumin and casts in the urine,—chronic interstitial nephritis. Now this is not at all right. Let me illustrate by a case which is being brought to our attention all the time. In 1915 a man of 37, in the course of an insurance examination was found to have high blood pressure, albumin and casts. The examiner—and he was associated with one of our big companies—told the patient that he had chronic Bright's disease and would be dead in six months. Of course this was a very foolish statement to make even if the man had chronic nephritis. However, since 1916 this man has been under our observation many times and has at no time shown any evidence of nephritis. For a year he has been having considerable myocardial disturbance and will probably die a cardiac death. But the insurance examiner and practitioner are not the only ones at fault. You will find the records of most of our hospitals show the same error. Even at the Peter Bent Brigham Hospital where we have been studying intensively nephritis and allied problems for a long time, we are now recognizing our mistakes of the past. Patients diagnosed several years ago

“chronic nephritis” are occasionally coming back to us and showing practically normal functional findings.

About four years ago a woman of 40 entered our hospital with hypertension, albuminuria and cylindruria. In spite of the fact that her function was practically normal she was diagnosed chronic nephritis with hypertension. About one year ago, she appeared again in the hospital and apart from the fact that her pressure was somewhat higher and her heart a little bigger, there was no change. Her urine was the same and so was her renal function. Had our original diagnosis been correct we should have expected our patient to show some toxic renal symptoms and her function to be much reduced. But up to the present time, this had not taken place. Our original diagnosis was incorrect.

Granting that in the past we have all made mistakes, it is now absolutely necessary for us to differentiate these two types of high blood pressure. In the first place, we must strive to be as accurate in the diagnosis of the lesion as is possible. In the true nephritic we have a small kidney and a lesion involving the glomeruli, tubules, and renal vessels, whereas in the true vascular case, the kidney is normal in size and the lesion—if any—is confined largely to blood vessels. Where the pathological differences are so great we should certainly strive to recognize them in our clinical diagnosis.

More important than the diagnosis, however, is the prognosis in these vascular cases. In contrast to the nephritic patient, death is very rare in uremia. Cardiac failure or angina is a more common cause. But by far the commonest cause of death, is cerebral hemorrhage. I think we owe it to ourselves, to our patient and especially to the patient's family to make the proper diagnosis and to recognize that his death is liable to be a sudden one. Now the true nephritic rarely dies a sudden death. There is no such thing as acute uremia. When a patient who has high pressure, albumin, and casts suddenly becomes

\*From the Medical Clinic of the Peter Bent Brigham Hospital, Boston, Massachusetts.

\*Read before the Providence Medical Association, March 1, 1920.

unconscious or has a convulsion, out of a clear sky, you are pretty safe in thinking that he is a vascular case and has but little nephritis. Let me illustrate by a case. Early in 1917, we had an old fellow whom we had diagnosed "chronic nephritis." On the way to one of Billy Sunday's meetings he suddenly had a convulsion on the street, and was brought in to us, unconscious. There was absolutely no paralysis, or other evidence of any localized lesion. If there were such a thing as acute uremia, we would have been justified in making such a diagnosis. The patient improved somewhat in the hospital until a week after entering, when he had another convulsion and died. Now remember, he had absolutely no localizing paralysis or other evidence of cerebral hemorrhage. At autopsy he had two huge hemorrhages in the frontal convolutions—the silent areas of the brain. The kidneys showed only very moderate arteriosclerosis with, of course, no possibility of uremia from such a lesion.

The treatment of these non-nephritic cases, too, has often been unnecessarily rigorous on account of the mistaken diagnosis. A marked and prolonged restriction in the protein of the diet is often a worthless and unnecessary hardship. A low protein diet, by its indirect effect of limitation of the total food intake, may be beneficial, but there is absolutely no evidence that it in itself lowers blood pressure or improves the symptoms. Clinical experience teaches us that patients, as a rule, need more protein than the minimum required to just keep them in nitrogen equilibrium. They may live on such a low diet and maintain their body weight, but they are weak and feel poorly most of the time. I have often thought that some of the symptoms we have attributed to disease should be charged in part at least to our treatment. It is quite surprising to note the improvement in general condition, strength, and feeling, when a patient who has been on a prolonged low protein diet is given a more generous and varied diet.

I do not wish to seem to decry the use of the low protein diet in either nephritis or in vascular hypertension, but it should not be continued longer than is necessary.

There is still another reason for differentiating these two diseases. It is said that if you see the

non-nephritic, high pressure case early, you can cure it. Now you practitioners are the only ones that see these cases early and it is up to you to cure them.

You can see how important it is to recognize this condition from the point of view of diagnosis, treatment, and especially prognosis. And it is quite easy to do so, clinically. If you will just remember that there is such a disease, you will be surprised to see how often you can diagnose it with a fair degree of accuracy.

Let us take some hypothetical cases for comparison. Your vascular case is typified by the business man of 45 or over, in whom there is a family history of apoplexy, cardiac or renal disease. He has always carried heavy responsibilities and has been "too busy" to take vacations. In appearance he is often of good color and is overweight from overeating. He does not look in the slightest degree like a sick man. He comes to you because of headaches or because he is abnormally tired. On examination his hypertension is found. If the patient is a woman, she is of similar type, usually in the menopause or near it, and is extremely nervous and irritable. Urinalysis in either case might show albumin and casts, and an ability to concentrate to a high specific gravity. This last is very important, as it is different from what is found in the severe nephritic.

A comparable nephritic patient is, in contrast, often a younger individual, pale, sallow, and thin. His symptoms include not only those vascular ones like headache, etc., but also toxic ones,—drowsiness, nausea, and vomiting, etc. Urinalysis shows albumin and casts just as in the non-nephritic case, but, as a rule, the ability to concentrate is much reduced.

A few words now about the blood pressure in these two diseases. While it is true that the pressures in both may be about the same, it is also true that the non-nephritic averages the higher pressure. It is perfectly fair to assume that any patient with a systolic pressure over 250 is primarily a vascular case and that he has little or no nephritis. In my experience at the Peter Bent Brigham Hospital, I have never seen but two cases of such pressures that were possible exceptions. Of course, this high level is not always maintained, and rest, quiet, and diet, may lower it to that level which is characteristic



of the nephritic. Should you first see your patient in this stage the blood pressure would not help in the differential diagnosis.

Clinically, therefore, it seems possible to diagnosis outstanding cases of high pressure without nephritis. Given a well nourished individual of good color, whose systolic blood pressure is very high, 250+, and whose urine shows an ability to concentrate well, the odds are much in favor of hypertension without nephritis as against the so-called interstitial nephritis.

But these patients are not always outstanding cases and, furthermore, it is desirable to prove your diagnosis. This can and should be done in all cases of hypertension by means of the tests of renal function. I shall speak only of the three in common use. The phenolsulphonaphthalein test consists, as you know, in the injection of this dye intramuscularly or intravenously and the collection of the urine at the end of two hours and ten minutes. This urine should contain in the normal individual 50 per cent. or more of the injected dye. It is by all means the simplest test and can be done by any one. It is, however, not very delicate. The blood urea nitrogen is more complicated and requires a laboratory equipment. It consists in the determination of the urea nitrogen of the venous blood. This, in the fasting individual should not be over 15 mgm. per 100 c. c.

The "two hour renal test" consists of specimens of urine collected every two hours during the day and one night twelve hour specimen. These specimens are collected while the patient is taking a diet consisting of a simple breakfast and supper and a heavy noon meal, containing a considerable amount of fluid, salt, nitrogen and diuretic substances. The normal patient should excrete a urine which, in the two hour periods, varies in volume, and concentration and amounts of salt and nitrogen. This may be modified—for simplicity sake—by determining only the volumes and specific gravity. The twelve hour night specimen should be small—not over 700 c. c. and its specific gravity, 1018 or over. The pathological case cannot so well vary the volume and amounts of water, salt and nitrogen. Nor can it concentrate to a high level. The maximum specific gravity, therefore, is lowered. The night urine is increased in amount and its specific gravity is decreased.

Now how much do these tests help us in differentiating between chronic nephritis and hypertension without nephritis? In almost every case they clinch the diagnosis. The vascular hypertensive case rarely shows a phthalein excretion under 50 per cent. The blood urea nitrogen is rarely abnormal and about the only abnormality in the two hour test is a tendency in some cases toward an increased volume of urine at night.

Having demonstrated the necessity and the ease of differentiating vascular hypertension from chronic nephritis, let us drop the latter and consider only the signs and symptoms of the former. These naturally fall into three groups related to the organs commonly affected—(a) the kidneys, (b) the heart, (c) the peripheral vessels. Of course, it must be remembered that it is the vessels that are primarily affected in both the kidneys and heart. If these vessels have been damaged long enough, secondary changes take place in the parenchyma of these organs, and these changes may then give rise to symptoms.

The average patient has no renal symptoms except nocturia. We usually find from time to time a little bit of albumin and a few hyalin casts. But these do not indicate nephritis—only renal damage from changes in the blood supply. The kidney itself is normal in appearance except for arteriosclerotic vessels and slight scarring due to obliterations, etc., of an occasional such vessel.

It may not be amiss to say at this point that a trace of sugar is occasionally found in these cases, too. This does not mean that the patient has diabetes.

Let us take up the heart next. Every patient who has this disease for any length of time shows sooner or later some cardiac disturbance. This may take any one of several forms. Do not forget that you may see your patient for the first time when the heart is badly decompensated and you may be led into the error of regarding it as a pure cardiac case. Dyspnoea is extremely common and may vary from slight breathlessness on exertion to the marked condition found in broken compensation. Another interesting type of dyspnoea is the paroxysmal smothering, coming on usually at night and often without immediate cause. In this type, the

patient is often awakened out of a sound quiet sleep by a terrific sense of smothering, referable to the base of the heart. It may last only a few minutes or may persist for quite a long time. It is very closely allied to angina, and may spring from the same cause. The next cardiac symptom to consider is cardiac pain. This may vary from slight feeling of weight or soreness over the precordia when tired, through all grades to the typical severe angina pectoris. Your patient may die in such an attack. Often there is associated with this, tenderness over the heart area. Lesser cardiac complaints are pounding, felt especially during excitement, and a skipping of beats.

As to signs—hypertrophy is present in practically every case, even the earliest. This may not be found by the usual methods of physical examination, but the electrocardiogram and X-ray show enlargement in almost every case. (We must, however, accept the evidence of cardiac enlargement from the X-ray with considerable reservation. Recent reports from the Army have shown that the X-ray seven-foot plates may show a shadow well beyond the accepted borders when the heart is absolutely normal.) There is no type of cardiac irregularity that is characteristic of this disease. Occasionally, if the myocardial changes are great enough, fibrillation may be found. Much more commonly we note extrasystoles. Of course, too, we may find weak sounds or variations in the force of the beats. If the heart can no longer stand the strain of the high pressure, "broken compensation" occurs. There is another interesting sign of cardiac embarrassment that is not often made out while listening to the heart but may be noted in the pulse and especially well while taking the blood pressure. I refer to the condition called *pulsus alternans*. This is extremely important and indicates a grave prognosis. It is very easily recognized and I would suggest that you look for it in every case. As you know, it consists of alternating weak and strong beats. You can recognize it with great ease if you will note the character of the sounds heard while taking the blood pressure. In a typical case you will hear only every other beat at or near the systolic pressure. When the pressure in the cuff has

fallen perhaps 20 or 30 mm., the second beat will come through. Sometimes instead of alternate beats falling out you will note that every other sound is a weak one.

Now we come to the signs and symptoms referable chiefly to the arteries. I shall try to be brief and shall hasten over the less important conditions. Roughly we may group them all into those involving the peripheral vessels and those involving the brain and cerebral vessels. In the former group we have nose-bleeds and excessive bleeding from any source. Muscle cramps in the calves and in the feet are extremely common and these are due to the insufficient blood supply through the narrowed arteries. Numbness, tingling and cold extremities are frequent.

It is well to speak at this point of the arteries themselves and the blood pressure. You may often be surprised not to feel or see any sclerosed or tortuous arteries in these cases. Occasionally, you make the mistake of judging by the radial artery alone. This may not be palpable. But feel for the brachial. It may be much thickened. In most cases the very small vessels,—if the retinal arteries are an index—are much more affected.

I have told you that the blood pressure is often extremely high. Remember, however, that it does not get that way all at once. It isn't as high when the process starts. Consequently, the pressure may be found at any level.

There is another very important thing to mention in connection with the blood pressure. It is extremely unstable and varies from second to second. A slight amount of exercise or the emotion caused by any stirring thought may drive up the systolic pressure 40 points inside of two minutes. On the other hand, the pressure may fall 30 points in 15 to 20 minutes as a result of physical and mental rest. This is extremely important to remember because variations of 10 to 30 points in either direction are of very little importance, unless they are progressive and in the same direction. We must be very careful in giving credit to any procedure which apparently shows a temporary reduction of a few points in the blood pressure.

Now let us go on to the cerebral symptoms, which frequently are responsible for bringing

the patient to your office. He may complain of any combination of the following symptoms:—irritability, nervousness, and extreme worrying; lack of concentration, loss of memory and of co-ordination; fear; sleeplessness; dizziness; ringing in the ears; and headaches. The latter are fairly characteristic. As a rule they are occipital and occur early in the morning. They often awaken the individual about 5 A. M., and disappear quickly when he gets up and around. The increased circulation seems to dispel this symptom. The adjustment to these headaches is rather remarkable. Many times these patients complain of excruciating headache in the earlier years of their hypertension with a systolic pressure ranging about 200. And yet two years later with a pressure around 250 they may notice little or no headache.

Occasionally the cerebral symptoms may be much more serious. There may be an increasing mental weakness. Again there may be a vascular crisis resembling a cerebral hemorrhage. There may be a very transient aphasia or paralysis of one extremity, etc., clearing up so quickly that it is hard to believe they are due to hemorrhage but must be caused by localized spasm of a cerebral vessel. The arteries in this disease are very prone to such spasms. The most extreme cerebral disturbance, of course, is cerebral hemorrhage—which needs no comment.

A constant symptom—which is hard to classify—and one that is present in almost every case, is tire on the slightest effort.

In the earlier part of my paper, I have spoken about the prognosis. Let me repeat what I said there. Most of these patients die of cerebral hemorrhage. Some die of angina or a definite myocardial break. Only a rare one shows a progressively increasing renal involvement with death in uremia.

Just remember, however, that this refers to the ultimate end. The fact that an individual has a high pressure does not necessarily mean that he is going to die right away. It is surprising how long some of these patients may live with a very high pressure. Without doubt some of them carry an elevated tension for five to ten years. I have one patient who is known to have had an increased pressure in 1910. I have another whose systolic pressure has vasil-

lated above and below 300 for a year. Both have had cerebral vascular attacks—but are still alive.

As to treatment I must say that the results in the older cases are far from satisfactory. Allbutt who has worked long and hard on this problem states that it is possible to cure many cases if you see them early enough, i. e., before the entire vascular mechanism has become set or permanently rearranged. This is of extreme importance to you practitioners because you are the ones who see them early. It is up to you to recognize the condition and to cure it. When permanent rearrangement of the vascular system has taken place we may no longer hope to cure, but, by the common sense modification of the therapeutics for cure, we may greatly postpone the eventual cardiac or cerebral outcome.

Let us consider for a minute what we are planning to treat. If we omit the cardiac element which may or may not need attention, we may say that we are to treat an individual who is overweight and nervous, who for years has been burning the candle at both ends as far as mental and physical effort goes and who now is found to have high blood pressure. The foundation of all treatment must lie in the resetting of the natural conditions of the patient. His whole life and habits must be re-vamped according to the motto—Moderation in Everything. This does not mean that he should be wrenched completely out of all his associations, but these must be pared down to within reasonable limits. We must teach him to realize that he must "slow up."

It is often well when this condition is discovered to insist on a good rest. This we may accomplish very successfully if we can get the patient to the hospital for study. Or we may send him to one of the numerous spas—the chief virtue of which for him would be the enforced rest in a pleasant atmosphere and the impression gained that vacations are desirable and beneficial. Of exercise I should say that moderate, regular exercise in the form of walking, golf, etc., is very beneficial in that it increases cardiac tone and in this way improves the circulation. Massage is undoubtedly of value, with perhaps, a weekly electric light bath. I insist on all patients resting for an hour a day. This ac-

compleishes a two-fold object—the actual rest and a definite break in the day's routine.

Diet is an important part of the treatment of this condition and much has been written by the advocates of low protein or low carbohydrate diet. I am fairly convinced that the diet question centers around the moderate restriction of all elements—to prevent over-eating—rather than the marked restriction of protein, carbohydrate or fats. There is no evidence as yet that a low protein diet lowers the pressure. It may indirectly, by a restriction in the total amount of food eaten, cause a loss of 10 to 15 pounds and be beneficial in this way. On general principles, it is well to restrict salt, condiments, alcohol and excessive tobacco.

A word on the effect of drugs. Outside of a very questionable benefit from potassium iodide and sodium iodide, I cannot say that any drug helps. Certainly there is not the slightest evidence that the nitrites are indicated. They have not even lowered the pressure, in my experiments. Furthermore, there has often been a short sharp rise of pressure following the administration of nitroglycerine. One must admit, however, that the latter is clearly indicated in the angina which is often present. Symptoms of course, like those indicating cardiac break should be treated in the appropriate way. Some of my women patients feel better when they are taking ovarian extract. Perhaps more of them would be benefited if we had stable preparations. A caution against the use of adrenalin; this drug often causes a terrific rise in blood pressure and one may get a cerebral hemorrhage as a result. One of my patients had a terrific attack of angina pectoris following its use.

Bleeding is about the only other measure that is indicated and this only when there is evidence of threatened cerebral hemorrhage or of right sided cardiac embarrassment.

Variations in pressure may be so marked under normal conditions that I have grown very conservative in my interpretation of the effects of any therapeutic measure except rest.

To summarize:—vascular hypertension is a disease entity characterized by the symptoms and signs I have mentioned. It can be recognized by clinical methods but more readily by tests of renal function. It is distinct from chronic Bright's disease. It is curable in the early

stages. You practitioners are the only ones who see the patient in this stage and it is up to you to recognize the condition and cure it.

#### CASE REPORT.

By DENNETT L. RICHARDSON, M. D.,  
Providence, R. I.

T. C., 10 years old, ill five weeks, was admitted March 30, 1920, and discharged April 3, 1920, against advice.

F. H. Three children. Other two are well.  
P. H. Negative.

P. I. Has been ill five weeks and confined to bed. Rather acute onset; at first complained of soreness around the scrotum—; examination by parents showed nothing; next day was confined to bed and could not walk. Developed slight fever—then chief complaints were pain in stomach, head, back and legs. Would cry out at times, and at other times was "sleepy." Was well until onset.

P. E. Well developed and poorly nourished male child of 10 years of age; semi comatose most of time; at other times of slow cerebration and slurring of speech. Makes occasional grimaces at times of contractions, as though in pain.

EYES. React to light and distance, pupils equal, no nystagmus, reflexes all present.

EARS. Negative.

NOSE. Deviations of septum to left, nearly occluding that naris. Septal ulcer on right.

MOUTH, ETC. Negative. Pharyngeal and all reflexes present.

HEART. Sounds faint but regular, tension fair.

LUNGS. Harsh breath sounds in bases posteriorly with sonorous and sibilant rales and fine crepitant rales by enforced breathing.

ABDOMEN. Not scaphoid; recti abdominalis rather rigid; reflexes absent.

EXTREMITIES. No rigidity of neck; irregular involuntary clonic contractions of legs and feet with occasional contractions of arms sometimes elicited by pressure on nerve trunk. No retraction of head.

NERVOUS SYSTEM, otherwise. No Koenig, Babinsky slightly present, Oppenheim not obtained, inco-ordination of both legs, heel to knee. Finger and nose test good; no loss of



pain or pressure sense over entire body, but reflex action is retarded.

Cremasteric reflex absent. Alternate (most of time) involuntary contractions of recti abdominalis in conjunction with transversalis abdominalis of same side; giving sacrum a twisting motion; these contractions continue while asleep. Knee jerks absent.

Involuntary micturition and defecation.

SKIN. Several small blebs, one on right thigh caused by extraneous condition; another about size of dime on dorsum of right second toe, another just appearing on mid dorsal region of left foot.

NOTES. Temperature between 99° and 102° for first five weeks.

March 31. Spinal fluid slightly under pressure, but clear; cell count 20, negative for T. B. and Wasserman. Blood culture negative. Urine shows large trace of alubumin. Esbach not done.

April 3. Discharged against advice.

DIAGNOSIS: Lethargic Encephalitis.

#### LETTERS TO THE EDITOR.

##### TO THE EDITOR:

To-day is hot, 90° F. and after the cold weather we found in Japan, I thought tropical weather would be very acceptable. It is so hot to-day, that we cannot go out much till late this afternoon. This morning Mrs. Rogers and I rode into the city (we are on the Bay about a mile from the business centre) where I bought a straw hat and a box of cigars and we were then ready to ride back. We started out this morning in one of the native carriages, seating two and the driver upon the dashboard, with very small native horses. When I got in he balked and wouldn't go at all. Then he began to dance and shy and we piled out and took an automobile.

Have not yet had an opportunity to get much idea of Manila, but it seems good to be under the American flag once more. I never liked the Japs anyway and I think less of them and more of the good old U. S. than ever before. Will probably have a chance to add to this letter before we leave, as we stay here till March 1st. Then we take another steamer—the Fushima Maru to Hongkong—and then after a week

there we board the Empress of Russia for Shanghai. I wrote you a long letter from Yokohama and I think told you about our visit to Mr. Ausno's residence for tea. We spent four days in Yokohama and then went to Kobe through the inland sea of Japan. Unfortunately we sailed late in the day and could only see part of the beautiful scenery that afternoon and early the next morning. We passed Shinoneseki about 7 in the morning and then were in this yellow sea till we reached Nagasaki. At times we were within a few hundred feet of the shore with towering mountains on both sides and all bathed in that beautiful purple haze with gray background which is characteristic of Japan. We passed hundreds of little islands and thousands of Japanese junks with their curious lantern sails and sampans by the hundreds.

Every bit of tillable land is utilized and the natives are crowded together like chickens in a coop. We spent two days in Kobe. One unfortunately was very rainy and we did not go ashore but the second day we took rickshas and rode about the city of 700,000 population. Had lunch at a hotel and came back to the boat in time to sail at 4.30 P. M. The women spent most of the time in the shops, but Dr. Peters and I walked to a hotel in the foot hills—the Tor Hotel—which was a wonderful place in a garden of several acres with fountains, waterfalls, Japanese bridges, shrines and temples. When we walked back we went into a public school and saw several hundred children go through their drills, showing evidence of German influence, as the goose-step was much in evidence.

We saw many curious sights in the poorer part of the city through which we walked. One in particular impressed me. We saw a woman draw water from a public well and wash her dirty clothes in the bucket, and then a man fill his water bag for drinking purposes without even rinsing the bucket. The children are cute, but all look alike and dress alike and most of them have skin diseases which render them unattractive.

We left Kobe at 4.30 and reached Nagasaki the next day about 5 o'clock. This is the city of all the Japanese shipbuilding and the harbor, which is wonderfully protected, is strongly forti-

fied and no cameras are allowed. If one is seen with a camera it is taken from him and smashed and he is arrested. The ship does not dock, but while at her mooring there are on each side about 50 big lighters carrying about 20 tons of coal. A sort of slip is let down for six or seven ports on the ship. Men form lines and while some shovel the coal into baskets (about 25 pounds) these are passed from hand to hand till they reach the ship. The last one empties the basket into a big hopper and with one motion hurls the basket back into the barge. They keep this up for all day, apparently free from fatigue and average about eight baskets every ten seconds. With about 16 crews working and from 20 to 30 in each crew, 2,000 tons are put on board in about eight hours.

A woman gave birth to a child, while working some time ago, and after an hour or so resumed her place in the line. On shore we saw many of the same sights. We visited a Buddha temple and a Shinto temple, bought curios. I stole a prayer paper from a shrine, and came back on the boat for sailing.

Manila is four days from Japan. When we reached here, after 30 days in the Tenyo Maru we had covered nearly 3,000 miles. We have gotten well acquainted with the passengers and found some very congenial friends and time passed very quickly. We have had an unusually smooth passage, although it is never very smooth on the Pacific, and have grown attached to the ship, and rather hate to leave her. Yesterday the Captain invited all our party to tea in his private quarters, and we had a pleasant time. He showed the women about the bridge. This was an honor not shown to any one else on board, though some of the rest seemed rather envious. There was one girl coming to Manila to get married and expected to meet her fiance on the dock. One day she foolishly told some of the women on board how nervous she was and said that she had never been kissed in her life. The news spread all over the ship and we all lined up at the rail to see the meeting. He was waiting for her at the foot of the gangway and the way he grabbed and kissed her would be worth a fortune on the screen. The hundred or so spectators gave a shout that must have made her jump. I saw her this morning

on the street with a great bunch of flowers, so I think she was married last night. It is time for tiffin, which means lunch, and afterwards we are going for an automobile ride, so I will quit for the present.

Yesterday morning we wandered around the streets and at 2 o'clock we took an automobile for a ride. About an hour later we went by crowds of natives and found that being Washington's Birthday, there was a big cock-fight, and so we went. It was like the grounds of a circus. Crowds of natives with stands of food (so called) and drinks. We climbed a rickety pair of stairs, through shouting, sweating crowds of natives to a private box overlooking the arena. There were not far from 2,000 around the pit all shouting and betting. Then a bell rang and two natives brought in two game cocks with sharp razor blades strapped on as spurs. They would grab one cock by the tail and push him towards the other till they got fighting mad. Then each took his pet and holding the head, allowed the other to peck him in the neck and get a taste of blood and then when the bell rang again they went at it. We saw two mains. The first one lasted about three minutes before one was killed, the other less than half a minute. Not very exciting unless you had a bet on, but interesting for a little while. I lost a peso by betting on the wrong bird. Then we drove some miles along the Pasig River and saw dozens of women in clouts doing their washing in the stream by beating the clothes on the rocks; and curious shaped boats loaded with produce on their way to town with long outriggers to keep them from tipping over. Then to Fort McKinley, where 10,000 U. S. troops are stationed and at 4.45 we arrived at Bilibid prison to see the "Retreat",—one of the sights of Manila. There are about 5,000 prisoners and 700 lifers. At this time of the day they all parade and go through their drill, some in blue, some in brown, and others in stripes, according to their behaviour. Eight were in white straw hats,—the only European prisoners. They had a band of about 60 and a troop of a hundred, all prisoners, that went through a very elaborate drill. Then all saluted the colors and filed by for supper. Those who were undergoing punishment, got none. This

morning we went again to the prison and I bought a lot of furniture made by the prisoners. It will be made and shipped to me some time this fall. This morning we had to get our passports vised. To-morrow we are going to drive to Cavite to see the Naval Station and Thursday to a mountain resort where we shoot the rapids a la Au Sable. The next day we go to Bagin to see some of the native negroes and their primitive way of life.

Manila, P. I.

F. T. R.

February 22, 1920.

TO THE EDITOR:

Since writing from Manila, we have had a strenuous time. Last Thursday we started in an automobile for Pagsonham, about 80 miles south of Manila, over very good roads and through great fields of rice and sugar corn, until we reached the foot hills where we began to see tobacco. About 40 miles out we passed Los Banos, where there are hot springs, and we stopped for a while and then went on up the mountains. At Pagsonham we had lunch at a native hotel, incidentally a wonderful cocoanut pie, and then we all dressed in our pajamas, (the ladies wore bathing suits) and the auto took us over to the river where we all got into dugout canoes with native paddlers, one for each boat. We started up the river, and after about two miles we struck the rapids and for two hours we went through the most wonderful scenery I ever saw. The river is not over a hundred feet wide. through gorges two or three hundred feet high covered with the most luxuriant tropical vegetation, with brilliantly colored birds, and the sides lined with beautiful flowers. When we came to a rapid the boatmen uttered weird cries and drove the canoe (hollowed from one trunk about 20 feet long and 20 inches wide) as far into the rapids as they could and then they jumped overboard and stepping from stone to stone or wading in water up to their shoulders, pushed the canoe through the rapids. At times it was all they could do to keep the canoe from turning turtle and starting down the stream. Then they would come to a smooth bit of the river and they would jump in and paddle a while till they came to another. We went on for an hour and a half, soaked to the skin all

the while, till we had passed six rapids and came to a waterfall of about 400 feet. The water was so high it was not thought safe to go farther and so after a little rest we all started back. It was some sport. We would shoot into the rapids and at times clear out of the water and with the boatman shouting all the while and steering skillfully. We passed between rocks and over shallows half filled with water and in ten minutes we had passed what took us two hours to ascend. We were in the canoe three hours wet all the while and we were all badly sunburned.

I had no idea there was any such scenery in the Philippines, but the next day we saw even more wonderful views. We had our breakfast at the hotel at 6 o'clock and took the train for a place in the mountains 130 miles north. We made up a party of 17 and Mr. Stone got the Governor's private car hitched to the train. We had a nice lunch and although it was very hot and dusty it was an enjoyable ride. We left the train at Maryarben and took an automobile for Bagnoi, the summer capitol of Luzon. It was a wonderful ride through towering mountains, across chasms hundreds of feet deep and around mountains thousands of feet high. We went in three hours to Bagnoi, more than a mile high and out of the heat into the pine forests and delightful temperate climate. We had an excellent hotel and the next day we spent riding about the mountains on wonderful roads to the various places of interest. This is the home of the Igorots and we saw them in all their native savagery. Stark naked save for a breech clout, perfectly formed specimens, and now a very industrious race and excellent workers. We saw them in their native homes, Nippa stacks built up on stilts and reached from the ground by a bamboo ladder. They eat dogs and as Sunday was the big dog market day we saw dozens of them climbing the mountains with six or eight dogs on a leash ready for the market Sunday morning.

That day was the birthday of one of the party, and we gave him a little dinner. The table was beautifully decorated with all sorts of flowers, bowls of roses with electric light beneath them, showing their colors beautifully, and just as we were seated, there was a wild hubbub

and in came two Igorot natives in their own costumes of a red sash, beating a big drum and leading a dog which they presented to him. Later in the dinner they came in with an enormous birthday cake, and paraded around the table with a big tomtom and dancing their war dance. This was a surprise and everything went off beautifully. Later they danced till midnight.

At 5 o'clock Sunday we had breakfast and went to market to see the natives and the dogs. At 7.30 we all got into a big French automobile and began the descent of the mountain by another route. We came down just a mile in an hour and a half and boarded our car at Bauang on the China Sea. We had a long, hot journey, back to Manila, but after a dinner at the Poodle Dog, a restaurant of some note, we went on board the "Fushimi Maru" for the night. It was very hot. Yesterday we sailed at noon for Hongkong.

S. S. "Fushimi Maru", March 2, 1920.

We had difficulty in getting hotel accommodations in Hongkong and so came to Canton last Wednesday; go back to Hongkong to-night. The trip is a hundred miles up the Pearl River on a very good boat but the river is so infested with pirates that there are two armed guards on deck all the while. The coolies are shut off from the main part of the boat by heavy iron gates. We have suffered greatly from the cold, coming from the heat of Manila and unfortunately we had on thin clothes, and our trunks were left in Hongkong. In our rides about the city we were very cold and the hotel is not heated. To-day it is a little warmer, but I am sitting in the writing room with my overcoat and hat on.

We are in the heart of south China and the sights are so varied and so interesting that I can hardly describe them. We ride about in Palanquin chairs on the shoulders of coolies. I was so heavy I had to have four, and the four men got only 20 cents an hour. The streets are very narrow, at times we were unable to pass other chairs. They average not over six feet in width and are crowded with natives all uttering shrill cries. There are stores on both sides, usually in guilds and markets showing rats, chickens, meats, entrails, snails, cockroaches, considered a great

delicacy, then fish, shrimp and all sorts of cakes of bright colors. Ivory shops where they carve beautiful objects, jewelry showing pearls and jade, (which by the way is very expensive.) Wood carvers, lacquer makers, silk embroideries and thousands of other things we never see at home.

To-day we visited the Canton Hospital and have strolled about with our guide. There are over 2,000,000 people crowded into the small city and 250,000 live all their lives on little boats. The children have pieces of wood strapped to their shoulders in case they fall over-board, and the cats and dogs are tied to the roofs of the sampan, or egg boat, as they call them. In front of our hotel, on one of the canals, there are at least 300 of these boats crowded together; some have families of eight or ten, and it is a common thing to see children of five or six, with a baby strapped on their shoulders working at heavy oars or poling the boat along. They cook in little charcoal stoves on the stern and sleep on a bamboo platform partly protected by a bamboo roof. Some are clean and have various colored hangings, but the majority are filthy and dirty as the Scallop-town natives. Cripples abound and there are scores of blind to be seen tapping their way thro' the crowded streets, uttering shrill cries. The weather has been overcast and cold. To-night we go down the river to Hongkong and to-morrow take a trip to Macao, the great gambling place. We went into a Chinese gambling place this morning.

Canton, China, March 6, 1920.

We left Canton Saturday night at 5 P. M. and reached Hong Kong about midnight but stayed on board till morning. It was a very good boat and compared favorably with our Sound boats. We had a large, airy stateroom. Have learned to like the curry and rice they serve everywhere. They give you a plate of rice, and then you add a curry sauce with hard boiled egg, then some chutney, some pickle, sliced bananas, grated cocoanut, and dried fish and mix it all into a thick mass. It is really very good, but you want to eat it with your eyes shut. At 9 yesterday we went on board another large steamer and went to Macao, a Portuguese con-



cession on the China Sea, about 40 miles from Hongkong. It is called the Monte Carlo of the Orient, as it is filled with gambling houses and opium dens, about the only place now where opium is sold openly. We took a ride of about 10 miles in ricksha chairs with two coolies to each chair; went into a gambling house and saw the inside of an opium joint with several men stretched out after hitting the pipe. Came back to Hongkong in time for dinner. This time we had good rooms, or as good as they have them, for they are bare floors, scanty furniture and about on a par with a dollar a day hotel, at home. The table is excellent and we have enjoyed eating again, although we long for a good drink of water. We have tea every afternoon and are getting fond of it. Hongkong is a cosmopolitan city of about half a million and from the window where I sit, I can see passing in the streets—English, Chinese, Japanese, Russian, Hindus, Indians, and Malays, all curiously dressed, and the streets are filled with them. A Chinese funeral has just gone by with gongs, image, hired mourners—making a hideous din. They had one here on Saturday that cost \$100,000.

Every foreign visitor to the United States is asked by the reporter, "What are your impressions of America?" and when I promised to write you my impressions of the Orient, I did not know I was going to have so many.

Every day something new and novel; some strange sights, curious scenes and odd customs, crowd one another so rapidly that it is a physical impossibility to adequately describe or even mention them. Even the sea voyage just completed of over 9,500 miles from San Francisco to Honolulu, thence to Japan—to Manila and then to Hongkong, on our way to Shanghai, has been one continual delight, and to those who love the sea, a never to be forgotten trip. Even my friend Peters, a notoriously bad sailor, has done justice to every meal, sleeps from 10 at

night till 8 in the morning, and takes a nap of a few hours in the afternoon, reads with comfort, smokes a good deal and also drinks a little, for we are no longer in prohibition territory.

At Honolulu Dr. Hanchett, a former interne at the R. I. Hospital, met us, and the day spent under his guidance gave us a new idea of this, the first of our insular possessions to visit. The Pali, the Punchbowl, the delightful climate, the native Hawiaan costumes, the growing wealth and importance of the Territory, its fruits and flowers, if adequately described, would fill a book, but our stay was limited and on January 29th, we started on our long trip across the Pacific and believe me it is some ocean. Ten days at sea, 3,500 miles sailed and never once till the day we first saw the Japanese coast, did we sight a ship. A congenial ship company, deck sports, moving pictures, concerts, whist, made the days pass quickly and on February 10th, at 8 P. M., we landed at Yokohama and got our first glimpse of the Orient. Although this preliminary visit to Japan included Yokohama, Tokio, Kobe and Nagasaki and my impressions are most vivid, I refrain from writing them, because later we spent a month in this island.

F. T. R.

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Dr. Frank J. McCabe, President; Dr. C. J. Astle, Secretary-Treasurer.

## EDITORIALS

### HEALTH INSURANCE.

The medical profession of this country would do well to give its attention to a sociological question which will very soon be pressing for solution, and which will affect our future welfare and happiness more than any other matter of legislation which has been proposed for many years. The subject of health insurance was thoroughly discussed before the House of Delegates at the recent

meeting of the American Medical Association in New Orleans, and that legislative body overwhelmingly voted that such legislation should not be endorsed at the present time.

The subject was further threshed out at meetings of several associations which met in New Orleans at this time, such as the Association of Industrial Physicians and Surgeons, The American Medical Editors' Association and in some of the section meetings of the American Medical Association.

It was the opinion of the majority of those who discussed the subject intelligently that

health insurance would work untold hardships on both the patient and the medical profession. The most convincing arguments were brought by an eminent medical statistician who spent many months in the countries of Europe where health insurance is in force, studying the situation.

Of the many salient points presented, we select the following: In case of illness the patient is obliged to call the panel physician for his district, and if dissatisfied with him, he can call another physician only after giving six months notice. Until recently in England it was necessary to wait one year. It would seem to be a fundamental law of human justice that a patient has the inalienable right of changing his physician whenever he is dissatisfied with the treatment he has received.

Looking at the other side of the picture the post of a panel physician is reduced to that of a petty clerk. His income is prorated according to the amount of work done and time consumed. If he makes a call five miles away the mileage allowed is more than if the call is one mile distant. If the road is poor he is allowed to charge more for that reason. If he dispenses four ounces of medicine and has only an eight ounce bottle for a container, he must explain the reason for using a larger bottle than is necessary. His life is a burden because of the immense amount of time consumed in calculating petty details like the above. His prescriptions are subject to scrutiny by a pharmacy board and he may be summoned before them to account for the use of an expensive drug. The pay is paltry in comparison with the time given, although the emolument has been increased several times. These few concrete examples have been given rather than generalizations because they serve to drive home the lesson that health insurance will make a slave of the medical man, and a puppet of the patient.

As nearly as can be determined, the promoters of health insurance in this country are seeking to have such legislation enacted for purely selfish reasons. They are politicians, demagogues, physicians seeking a job under the provisions of such an act, industrial engineers, a certain type of social worker and legislative cranks. Every unbiased person

competent to judge, whether medical man or laborite, is strongly against such legislation. They agree that state medicine would be eminently more satisfactory. It is well to give our thought to this subject for it is fraught with danger to the body politic. If enacted into law, such legislation would increase taxes to such an extent that the debts of the recent war would seem like a drop in the bucket.

#### VACATION TIME.

It seems to be a matter of pride with many medical men that they either never take a vacation as a matter of principle or else are too busy to leave their importunate patients. Is this a matter to be proud of or to be ashamed of? It is perfectly proper for the physician to consider his patients in a matter of this kind, but is he treating his patients squarely by not giving his mind and body an occasional rest? Can he not do more justice to his patients by getting out of the rut that every man falls into who does not seek change for mind and body? We are all machines, but the human machine differs from the automobile and similar complicated mechanical wonders in one very important respect—our parts are not replaceable. It is true that a damaged heart can be made compatible with a limited existence; it is true that the kidney can be affected and the owner still be fairly comfortable; it is true that a moderate hypertension will keep within limits if properly handled; it is true that an irritable nervous system may only be a source of annoyance to the owner. Is it worth while for physicians to run the chance and be forced to contend with a damaged organ, when this danger can be avoided?

Many physicians claim that they cannot afford to take a vacation, but, if they considered the matter in the true light, they really cannot afford to continue without a vacation. In the first place they owe it to their dependents that they should keep their body in such condition that their productive years may be many and that their names are kept away from the obituary page of the JOURNAL until they have passed the three-score mark. They also owe it to their patients who have trusted them with their lives that they keep their

minds alert and ready to meet the emergencies of practice. Unless a physician leaves the responsibilities of a busy practice and renews his acquaintance with the best thought of the profession, he is not practicing medicine as it should be practiced. He is either marking time or even stepping backward while the rest of the procession marches steadily onward.

#### THE DOCTOR AS TEACHER.

The dictum of the late P. T. Barnum that "The public loves to be fooled" has had no greater application than in the treatment of those afflicted with disease. To succeed in fooling the well, ordinarily demands much cleverness and ingenuity, but the sick are all too ready to grasp at any illusion that may offer them comfort and hope and are incapable of critical judgment. It is a matter of common knowledge that fooling the sick is easy and is the profitable occupation of the quack, whose statements are even more persuasive if it be true that to a great extent he fools himself and half believes his own teachings. But in the ranks of the regular profession, the gentle art of keeping the public misled or at least mystified has in the past been found expedient, and we must admit that varied phases of self-deception are represented among us, from the man who is *sure* of the beneficial action of his favorite prescription in the treatment of influenza, to him who can see a fountain of youth in a culture of lactic acid bacilla or make a parasite of a blood platelet.

At the present day, however, a great part of the public has developed a very healthy desire to be fooled no longer, but to know the facts as far as they can be known. The future of medicine lies in the education of the public in medical matters. Campaigns of publicity regarding tuberculosis and venereal disease are a part of this movement, which, when carried out to its logical conclusion, means destruction to charlatanism and quackery. But there is another side to be considered. When the doctor of to-day makes his family visits, he should see to it that he gives his patients as clear and concise a statement of the truth

in regard to the nature of their ailments as is suited to what he thinks is their ability to understand. If he merely looks wise and prescribes treatment and vouchsafes little or no information to his patients, he is shirking more than half his duty. When the public realizes that the medical man is anxious to take his patient fully into his confidence, to play fair, with all his cards face upward on the table, and when the main facts regarding the nature of disease and its prophylaxis and treatment become matters of common knowledge, the death knell of charlatanism, quackery and cults will have sounded.

#### PROGRESS IN STUDY OF THE NEUROSES.

An interesting and wholesome attitude is apparently being taken towards the etiology of the neuroses which should in the future yield knowledge that will enable the clinician to deal more intelligently with a class of patients that are a source of great annoyance to themselves, their friends and the doctor. Interesting articles upon neuropathology, work in chemical physiology and studies upon glandular activity all point in a progressive scientific direction. To have ascribed the early ideas of grandeur of a beginning paretic to an infection of the brain by a micro-organism would have been laughed at years ago yet today such flights of fancy in a middle aged man suggest at once that a cord Wasserman be done. To transform a myxedematous dullard into a useful happy person by small pills of dried sheep gland would also have been beyond the realm of possibility. Is it then too much to expect that an organic foundation will be found for such a distressing state as an acute anxiety neurosis? A most hopeful incentive for such knowledge is the fact that most neurotics are essentially good, truth seeking individuals and well worthy of all that science can give them in the direction of good health. Undoubtedly the world will continue to produce great numbers of erratic characters who will defy anything more than mere classification but it is likely that the future will see many of the mild neuroses and psychoses put upon such a solid etiology that treatment will be substantial and perhaps really curative in a way satisfactory to the unfortunate individual.



## OUR GRAND OLD MAN.

Dr. Horatio R. Storer quietly observed his 90th birthday on February 27, 1920, at his home on Washington street, Newport.

On being graduated from Harvard in 1850 Dr. Storer went to Europe for further study and for a year was assistant to Sir James Simpson of Edinborough, the discoverer of chloroform. Four years later when Dr. Storer returned to America, he did much to popularize the use of chloroform in this country.

He became a pioneer in the modern treatment of diseases of women and built up a large practice. As a result of his work along this line he was made an honorary member of practically all the medical societies of the world. He founded and was long the editor of *The Boston Journal of Gynecology*, the first medical periodical in the world devoted entirely to diseases of women.

In 1872 he became infected while operating. For five years he sought health in Europe without avail and since then has been a semi-invalid.

He settled in Newport in 1877 and still lives there. He takes active interest in every sort of problem and important question and all his life has been a champion of the "under dog."

He founded the Newport Natural History Society. His hobby has been the collection of medals that, in any way, have bearing on medical science and he presented a collection of 2,500 of these to the Boston Medical Library.

Many years ago he began a fight for a constructive policy in medicine. Not only at Newport, but in Boston and other places, he has been an indefatigable worker for methods of disease prevention rather than waiting for spread of the disease. He has never lost his interest in furthering this cause and has recently been given the degree of LL.D. by Fordham University, in recognition of his activities.

Dr. Storer loves Newport, the city he has made his home for the past 30 years. He said: "Many years ago I discovered that Newport is a charming place in which to live, and I then decided to make this city my home." One of the incidents in the making is the fact that he has made it a home for others as well, as the very next door to his own domicile is the home of the Sisters of St. Joseph's Church, which

was formerly his own residence, called "Fairhaven," and which he gave to the Church. The Sisters find inspiration in frequent calls upon Dr. Storer, and several of them called to offer him congratulations upon his birthday.

In politics Dr. Storer has always been a Republican with a leaning toward prohibition.

"I was once a mugwump," said the doctor, in an interview, "and I feel today that we should be more independent in our choice of men to represent us in any form of government." He then went on to tell of some interesting episodes in his associations with Daniel Webster, of whom he was an ardent follower until their political ideas reached the cross roads, as it were.

Dr. Storer is in exceptionally good health, and his optimistic disposition brings happiness to those who come in contact with him. His room at his residence on Washington street faces the harbor, and the view is conducive to study and has been enjoyed by him while preparing many manuscripts.

Dr. Storer received his A. B. at Harvard in 1850, A. M. and M. D. in 1853, and LL. B. in 1868. His achievements in medicine have been of such a nature that for many years he has been celebrated. His personal life, however, is more interesting to Newport, and his home on Washington street gives much cheer to those who call, on account of his remarkable personality.

On March 25, 1920, he succeeded to the title of the oldest living graduate of Harvard University.

## SOCIETY MEETINGS

## PROVIDENCE MEDICAL ASSOCIATION.

April 5, 1920.

The regular monthly meeting of the Providence Medical Association was called to order in the Medical Library by the Vice-President, Dr. Frank T. Fulton, on April 5, 1920, at 8:55 P. M.

The records of the previous meeting were read and approved.

The applications of Drs. Henry D. Wilson, Alfred A. Calderone, John J. Gilbert and Alfred F. McAlpine having been approved by the Standing Committee and there being no objection, all were elected by an affirmative vote.

The Chairman announced a committee to draw up a memorial on the death of Dr. Harry W. Kimball as follows: Dr. William J. McCaw, Dr. George A. Matteson.

There being no further business the chairman introduced the speaker of the evening, Dr. Lewis Webb Hill of Boston, Massachusetts, who read a very interesting and instructive paper entitled "Acute Nephritis in Childhood".

The subject was thoroughly and practically presented, and called forth an unusual amount of discussion from the members, the following taking part: Dr. H. G. Calder, Dr. W. P. Buf-fum, Dr. H. Terry, Dr. A. Corvese, Dr. J. S. Moore, Dr. J. E. Kenney, Dr. William Hindle, Dr. F. T. Fulton, and was closed by Dr. Hill.

Dr. William R. White moved a rising vote of thanks to Dr. Hill which was given, and followed by adjournment at 10:25 P. M. Collation was served. Attendance: 39 members and seven guests.

Respectfully submitted,  
RAYMOND G. BUGBEE, M. D., *Secretary*.

#### WOONSOCKET DISTRICT SOCIETY.

The Woonsocket District Medical Society held a meeting, April 22, 1920, at 4:30 p. m. at the office of Dr. Walter C. Rocheleau, Hamlet Ave., Woonsocket.

Paper: "Cardio-vascular and Kidney Disease" by J. V. O'Connor, M. D.

T. F. BAXTER, M. D.,  
*Secretary*.

The Woonsocket District Medical Society held a meeting, May 20, 1920, at 4 p. m. as the guests of Miss Lucy Ayers, matron of the Woonsocket Hospital.

Paper: "Recent Post Graduate Impressions and Recommendations for Hospital Efficiency" by William F. Barry, M. D.

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### HOSPITALS

#### ST. JOSEPH'S HOSPITAL.

The regular meeting of St. Joseph's Hospital Staff Association was held at the Medical Library, May 14, 1920, at 8:30 P. M.

Paper by Dr. John H. Homans, Boston, Mass.,

visiting surgeon to the Massachusetts General Hospital. Subject: "Studies in Metabolism".

#### PROVIDENCE CITY HOSPITAL.

Dr. Merrill O. Parker, left on March 21st, after a three months service at the City Hospital to go to the Manhattan Maternity and Dispensary in New York.

Dr. William Holt began a six months service on April 1st.

### BOOK REVIEW

SURGICAL SHOCK AND THE SHOCKLESS OPERATION THROUGH ANOCI-ASSOCIATION. By Crile and Lower. W. B. Saunders Co., 1920.

Drs. Crile and Lower state that they have rewritten their book in the light of the experiences they have had in the war surgery and the corroboration of the principles of anoci-association there received.

As the basis of their theory the authors have taken a familiar theory of the embryologists. Ontogeny is the recapitulation of phylogeny, i. e., the development of the individual simulates that of the race. All our actions follow associative good or bad memories. These may be of benefit and are called beni-associations, or harmful and called noci-associations.

Throughout the race these noci-associations have been followed by attempts to avoid or combat injury and these attempts Crile calls anoci-associations. Motor activity follows the stimulation of nerve ceptors and any such activity causes changes in the cells of the brain cortex, adrenals, liver, etc. Excessive stimulation causes severe destructive changes and we have a state of "exhaustion" or "shock" which is most readily caused by trauma of the parts most richly supplied with sensory nerves. Here follow some interesting observations on the shock dealing effects of different types of trauma and their relation to environmental forces. Crushing and tearing injuries common through the ages are very shocking. The sharp knife or the modern high speed bullet do not act so. Heat has always been with us but the X-ray has not. The first produces shock, the second does not. The abdominal viscera have always been liable to perforations and infec-

tions. Hence pulling on the mesentery which resembles the pulling of distention causes pain although cutting or burning the bowel does not.

Identical changes follow from many causes as emotion, physical injury, hemorrhage, muscular exertion, chemical poisons, etc. When these cell changes have taken place normal muscular or mental energy cannot be produced. They consider these conditions to be the result of an intra-cellular acidosis. Looking upon shock as an interference with the mechanism for the transformation of energy they call their interpretations the kinetic theory of shock.

There are in the book many photomicrographs to illustrate the cell changes via (a) chromatolysis, (b) alteration of nucleus plasma relation, (c) rupture of the nuclear and cell membrane and (d) disintegration of cells.

From experiments the authors conclude that general anesthetics do not break the afferent path from the seat of injury to the brain and cell changes may take place as readily as though no anesthetic was given. On the other hand as emotion may cause the same changes local anesthesia alone is insufficient. The kinetic system can be over activated by both traumatic and emotional stimuli. Hence the complete exclusion of both, will wholly prevent the shock of surgical operations. Their experiments showed that trauma under ether caused greater cell changes than under nitrous oxide.

"On the kinetic theory already enunciated—a new principle of operative surgery has been founded. Every adequate stimulus with or without inhalation anesthesia whether from trauma or emotion predisposes to shock—obviously the only practical method of protecting the brain is the development of an operative technic which will exclude from the brain the stimuli of the special senses and the stimuli of common sensation and the employment of an anesthetic agent that does not harm but rather acts as a protection to the brain cells."

Very careful directions are given as to technic including several chapters on special operations. In general it is as follows: preliminary morphine and scopolomine; nitrous oxide oxygen anesthesia; novocain used as

carefully as though the operation was under local anesthesia alone; quinine and urea hydrochloride in certain cases, careful dissection and very gentle manipulation of tissues.

The authors have evolved a very ingenious theory and adroitly woven with it numerous phylogenetic doctrines and physiological facts.

In some cases where the facts and doctrines are not frankly compatible the condition is not dwelt upon.

References are made to an enormous amount of experimental work. Detailed accounts of such experiments would have made a bulkier and less easily readable book but would have carried more conviction.

Dr. Crile is recognized as a wonderfully dextrous and painstaking surgeon and his results are undoubtedly unusually excellent. Well given anesthetics; attention to the mental and physical condition of patients; intelligent operating with skilful dissection and gentle manipulation of tissues will produce good results even though the kinetic theory is a fallacy.

More detailed proof and the corroboration of numerous sceptical investigators are necessary for the acceptance of the kinetic theory of shock.

P. P. C.

### MISCELLANEOUS

#### A FEW IMPRESSIONS OF THE NEW ORLEANS MEETING OF THE AMERICAN MEDICAL ASSOCIATION.

The American Medical Association met in New Orleans this spring after a lapse of 17 years. During this period the city has changed from one having a distinctly foreign air to an up-to-date American city with a picturesque French quarter and a suggestion of the Spanish occupation remaining in the architecture and names.

Over 3600 physicians registered, the majority coming from the Mississippi valley and the nearby Southern states. New England and the Middle Atlantic states were poorly represented. Possibly this circumstance had an influence in the decision to hold the next meeting in Boston.

The section meetings were well attended and the scientific and commercial exhibits were complete and interesting. Lantern slide

and moving picture demonstrations were held daily and were well attended. The hospitals of the city held clinics on the days preceding the session and drew a large attendance.

Rhode Island was well represented at this session. Dr. Frank E. Peckham presented a paper before the section on Orthopedic Surgery. Dr. Albert H. Miller served as president of the American Society of Anesthetists, which, in connection with several other independent organizations, held meetings several days before the Association sessions began. Dr. Roland Hammond, vice-chairman of the section on Orthopedic Surgery, presided over the sessions of that section.

Several unique entertainments were provided for the guests which were thoroughly enjoyed. The opening meeting was held on Tuesday evening in the Shriner's Temple, St. Charles avenue, which was taxed to capacity, many being obliged to stand throughout the long session. This meeting is always impressive from the distinguished personages taking part, and this year was no exception to the rule.

The President's Ball, held in the Athenaeum on Wednesday evening, was the most characteristic entertainment of the entire session. The hall was decorated with flowers and smilax worked in trellis bordering the dancing floor, with electric illuminations making up a veritable Fairy Garden. The appointments were similar to those given by the Greater Carnival Organizations during the famous Mardi Gras Festival. The programme opened with a magnificent representation in a series of tableaux of Moliere's "La Malade Imaginaire". The cast was composed entirely of physicians, both local and from other states. The costuming was elaborate and the tableaux were presented in strict accordance with the traditions of the classic French stage of the 17th century.

In the second act the King and Queen of the ball, seated on the throne and surrounded by maids of honor and dukes, received the President of the Association. Then followed a Drill by the Shades of ancient physicians, elaborately costumed and representing the medical man from earliest civilization throughout all ages and climes. All partici-

pants were masked and remained so throughout the evening. The maskers then selected partners from special call-out seats and the dancing began.

On the following evening a Fete Champetre was given at the City Park. This beautiful outdoor pageant, illustrating the Aesculapian period of medicine at the Temple of Cos, was staged in front of a peristyle in the park, which formed a splendid background for the entertainment. This consisted of a series of dances and processions with interpretations of the dreams of patients by the votaries of Aesculapius. The cast was composed of medical students at Tulane University and Newcomb College girls. The costuming was in classic Greek style and the lighting effects were very beautifully produced.

Walking trips through the "Vieux Carre"—old French and Spanish New Orleans—were popular, and many quaint spots were discovered strongly reminiscent of the old world. The levees were a source of interest at this time, for the river was at the highest level, except once, in the history of the city. The numerous cemeteries,—one for each church and fraternal order,—were viewed with much interest. On account of the fact that water is found four feet below the level of the ground, it is necessary to use vaults and tombs and place them on the ground. Excellent French restaurants were found in numbers. The viands were novel and delicious, especially the fish and shell fish in which the state abounds. The dishes a la Creole and the French drip coffee will linger in the minds and palates of many a visitor for years to come.

There is a popular misconception as to the meaning of the word "Creole". A Creole is a white person of pure French or Spanish blood, who was born in Louisiana. There is no admixture of negro blood in the pure Creole. The word is a synonym for the best in the state, and hence we have it used for other things, such as "Creole eggs", "Creole chickens" and the like. These people are very proud of their ancestry and invariably keep the shades of their houses drawn and their houses closed except to those who enjoy their confidence.